

Icon Medical Solutions, Inc.

11815 CR 452
Lindale, TX 75771
P 903.749.4272
F 888.663.6614

IRO REVIEWER REPORT TEMPLATE -WC

DATE: November 16, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

30 Hours of xxxxx Post Acute Day Neuro Program (6 Hours per day, 5 days per week).

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

The reviewer is certified by the American Board of Psychiatry and Neurology with over 34 years of experience.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld

(Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male who was injured when he was struck on the head while he was working on xx/xx/xx.

The claimant was evaluated in the Emergency Room. Documentation notes that he was hit on the head at. He complained of a "blow to head" injury. The severity onset was mild, and there was no pain radiation. He reported nausea and vomiting and denied LOC. He reported dizziness. He reported no prior similar symptoms. On exam, he was alert, oriented x 3, and in no acute distress. PEERL, EOML, NL eyelids-periorbital, no signs of skull injury, nystagmus (horizontal). ENT atraumatic. Neck atraumatic, nontender, full range of motion, no distracting injuries, no masses or swelling. Respiratory/chest atraumatic, no respiratory distress. No motor or sensory deficits. Glasgow Coma Score 15. Lab values were normal except creatinine of 1.4 and glucose of 135. CT scan demonstrated unremarkable noncontrasted CT of the brain with no evidence of acute large vessel infarct or intracranial hemorrhage. Assessment: Patient states he feels much better and wants to go home. Patient is non-toxic, active, tolerating PO fluids, able to ambulate without assistance. States his dizziness is resolved. PRIMARY IMPRESSION: Concussion. SECONDARY IMPRESSIONS: Dizziness, head injury, vomiting, work place accident. Discharge to home. Prescriptions given for Ultram, Phenergan, and valium.

The claimant was evaluated for chief complaint of concussion/head injury. He complained of headache, ringing in the ears, and memory loss. He stated that nothing would make the symptoms better. ROS positive for nausea and vomiting. He stated, "I feel like I'm in a fog." On exam, he was alert and oriented and in no distress. He had moderate tenderness to the left frontal area. He had mild cervical muscle spasm. No motor or sensory deficits. He

was prescribed Mobic and Flexeril. He was released to return to work at light desk duty.

The claimant was evaluated for chief complaint of recheck concussion "better." His pain scale was 0/10. Associated signs/symptoms were negative for headache, negative n/v. He stated, "I'm ready to get back to work." Exam was unremarkable. He was not given any prescriptions. Instructions were to "Prepare for discharge next week."

The claimant was evaluated for chief complaint of recheck concussion "not any better." His pain scale was 0/10. ROS was negative for tingling, numbness, or weakness and positive for nausea. He stated, "I'm having some headache issues and kind of unsteady." It was noted that he could not remember passwords that he used every day. He complained of tinnitus. He stated that he had no memory of the accident and was confused since the incident. He complained of some dizziness and every-day headaches. He stated that he could not do normal job description. He stated, "My biggest problem is I'm confused." He complained of trouble sleeping. It was noted that tinnitus had gotten better but not fully resolved. Exam was unremarkable. An MRI brain was ordered.

MRI brain w/o contrast report. IMPRESSION: No intracranial mass, hemorrhage, infarct, or hydrocephalus is seen. No abnormal signal is seen in the brain. Ethmoid sinuses are severely opacified. The other sinuses are moderately opacified. Fluid is seen in the right maxillary sinus.

The claimant was evaluated for chief complaint of recheck concussion "better." Associated signs and symptoms were noted to be dizziness, forgetfulness, and sleeping more. He reported depression symptoms and increased sleepiness. Exam was unremarkable. He was referred to neurology for post-concussion syndrome. No prescriptions were given.

The claimant was evaluated. He complained of forgetfulness, fatigue, and depression. He complained of emotional outbursts, crying, and feeling depressed. He said that he was still struggling with passwords. Exam was unremarkable. Note was made to check on neuro referral.

The claimant was evaluated. He stated that he recalled experiencing severe headaches for a few weeks after the incident. He still noted problems recalling passwords and how to reset them. He mentioned that he forgot his son's school function. It was noted that "witnesses reported that he was unconscious at the scene." Note was made that he sometimes felt he was in a daze. His headaches were treated with ibuprofen and rest. He was sensitive to light. It was noted that he had not previously experienced significant headache. He reported weight loss and feeling depressed. MRI brain scan report and images were reviewed, which appeared normal. It was mentioned that he slept excessively. It was noted that he returned to work a few days after the injury. Past medical history was remarkable for right thumb amputation at birth and partial thyroidectomy. His current medications included ibuprofen. On exam, cranial nerves III-XII were normal. Motor exam was normal, including normal strength and reflexes in all limbs. Cerebellar exam, station, gait, and sensory exam were all normal. Tandem gait was normal. ASSESSMENT: This patient relates a history of a traumatic brain injury with loss of consciousness. His current symptoms and memory impairment are symptoms of a post-concussion syndrome. He also suspects that he may be depressed. PLAN: I assured him that his symptoms will eventually remit. We discussed a trial of antidepressant medication. He wants to use Wellbutrin, which was not useful for him. Instead, I prescribed Effexor and a follow-up was scheduled.

The claimant was evaluated stating that he felt depressed and slept excessively. He had returned to work at full duty. His medications included Effexor 75 mg daily and Lipitor. Psychological testing by computer was noted to indicate mild depression. ASSESSMENT: I suspect he is still depressed. He still has problems with motivation. PLAN: We had a 25 minute discussion regarding his symptoms. Effexor will be increased 150 mg daily.

The claimant was evaluated. He reported that he worked overnight and, when he was not asleep, he was not very active and may sit for hours. He reported that he functioned well at work with reminders. He did not feel that Effexor had helped those symptoms and psychological testing revealed only mild depression. His headaches were now infrequent. Exam was unremarkable. ASSESSMENT: His post-concussion symptoms have improved, but he is still having significant problems with motivation. PLAN: We discussed moving forward with a neuropsychological evaluation, and he agreed. Meanwhile, he will continue Effexor.

The claimant was evaluated. He said that he had been doing well except the week prior when he experienced severe headaches on a daily basis, which he treated with ibuprofen. He had been free of headache for 2 days. He mentioned that he had noted impaired left-side hearing since his injury, which was ipsilateral to the location of his injury. It was noted that neuropsychological evaluation was canceled when it was discovered that the psychologist was out of network. He was not examined at this visit. ASSESSMENT: He now reports a history of hearing loss which is related to his injury. He has not yet had a neuropsychological evaluation. PLAN: He will be referred to an ENT specialist for an audiogram. A neuropsychologist in his network will be located, and he will be referred for testing. A follow-up was scheduled in four weeks. Because of the above conditions, I do not feel that the patient is at maximum medical improvement.

DDE: has ongoing hearing loss in the left ear which needs to be evaluated. He will also need to see a neuropsychologist prior to being at MMI. Therefore, based upon the above-described information and rationale, it is my medical opinion that future estimated date of MMI would. The diagnosis in dispute is 311 Depression. I have reviewed the medical records and talked to the patient regarding the diagnosis of depression. Although there are some references to depression in, I did not find anything during my exam and conversation with the patient to indicate that he is suffering from depression. The patient indicated to me that he does not feel depressed. Consequently, the diagnosis 311: Depression is not part of the compensable injury.

The claimant was evaluated for a neuropsychological evaluation. DIAGNOSIS: Mild cognitive impairment due to head trauma; major depressive disorder, single episode, severe, without psychosis. RECOMMENDATIONS: Physician consultation is recommended to assist with a sleep is recommended. His situation is special given he is a night shift worker whose circadian rhythms are likely disrupted. His sleep need to be addressed quickly and the ideal situation is to temporarily work day shifts and/or take time off for the best and fastest therapeutic effect toward baseline functioning. Physician consultation is recommended for brain-supportive nutraceuticals to support brain healing and functioning and to fill in nutrition gaps that may further compromise general health and the healing process. As aforementioned, I am concerned about his current level of functioning at 6 months post injury – typically, the level of healing at this point should have been more substantial on test data for the college-educated individual. Cognitive rehabilitation with evidence-based protocols is recommended for due to significant evidence of cognitive impairment in the current evaluation in the areas of memory, learning, processing speed, and executive functions. Adding biofeedback to his rehabilitation plan may also help to improve stress management and sleep – both of which have a significant interplay to general and cognitive functioning and healing. Physician-approved exercise is recommended to improve mood, and physical activity can reduce neural inflammation and facilitate recovery after brain injury. This is safe to do given it is 6 months post-injury. This will also assist in losing the 30 pounds he has gained post-injury, which is also contributing to fatigue. Well-balance meals with adequate protein, slow digesting carbohydrates, and leafy greens are recommended as well as adequate amounts of water to prevent dehydration. Poor nutrition and dehydration can interfere with cognitive and physical health in the average individual, let alone an individual suffering from a TBI. basic and instrumental ADLs are intact; however, he is making numerous mistakes at work in the form of forgetfulness. He reported a plan to take a 3 week vacation due to having considerable unused vacation hours, which is an excellent idea to give his brain a chance to heal. In fact, it is recommended that he take the maximum of his vacation (and additional leave of absence if necessary) now. This is especially important for two reasons: (1) He was not informed by his original treatment team to avoid the use of electronics, take time off, or use brain supporting nutraceuticals and missed a critical window for the therapeutic response, and (2) since he works the night shift, he is at a disadvantage compared to an individual with a normal sleep schedule because he already has to manage disrupted circadian rhythms that may interfere with the healing process. The more he can resume a regular sleep schedule will assist with healing and have both quicker and better long-term outcomes. When he returns to work, he will require accommodations at work as his brain continues to heal. (The ideal situation is to be placed on day shifts, if at all possible, for temporary or permanent basis.) Given his hearing loss, safety precautions should be put in place on the job to accommodate for reduced hearing. The accommodations specialist in his job's HR department should be able to assist with this. Continue to use compensation strategies (organizers, planners, alarms) to assist with daily functioning.

Audiogram Test Result. Otoscopy visualized TMs bilaterally. Tympanometry is c/w normal TM mobility bilaterally.

ARTs.

The claimant was evaluated. He reported that he had a hearing test that showed signs of significant hearing loss in his left ear and he was to be fitted with a hearing aid. reviewed his neuropsychological evaluation "showing evidence of mild cognitive impairment from his traumatic brain injury." He stated that he believed that Effexor may have been causing him impotence at the 150 mg dose. stated that his neuropsychological evaluation indicated that he was depressed. He was to visit his PCP about Lipitor to see if it could be stopped and substituted with a non-statin because of concerns it may be affecting his memory. He was not examined at this visit. ASSESSMENT: He is still symptomatic from his head injury. PLAN: We discussed changing his antidepressant medication to Wellbutrin, but he wanted to remain with Effexor. The dose will be increased to 225 mg daily and a follow-up was rescheduled.

The claimant was evaluated. He reported that his neuropsychologist indicated that he should remain off work at this time. He last worked. He reported that he used indomethacin at bedtime and reported fewer and milder headaches on awakening. He reported no side effects from the increased dose of Effexor. He did report difficulty falling asleep, and recommended that he try Benadryl at bedtime. He had not yet gotten his hearing aid. He was not examined at this visit. ASSESSMENT: His condition is stable. PLAN: Continue treatment and follow up in two months.

The claimant was evaluated. He reported that he had been having occasional severe headaches, which he treated with indomethacin and ibuprofen. Note was made that he saw a "functional medicine" doctor who prescribed some sort of dopamine medication. It was mentioned that he was referred to him by his neuropsychologist. His headache frequency was 3-4 per week. stated that he would begin cognitive therapy on. He reported compulsive behaviors. His medications were Effexor 225 mg, nortriptyline, and "others listed in his chart." He was not examined at this visit. ASSESSMENT: His headaches are still severe and frequent. PLAN: His dose of Effexor will be reduced to 150 mg daily and Prodrin was prescribed for headache treatment. A follow up was scheduled.

The claimant was evaluated, who recommended specialized brain injury rehabilitation program to include a structured environment which will be provided 5 days/week, 6 hours/day.

UR. RATIONALE: The provided records show that the patient was injured in, was seen in the ED, and released on the same day. It was uncertain if the patient lost consciousness, as the patient did not remember the event. The ED records or any other records from the time of the injury are not provided. It's not explained why the patient would be discharged home from the ED if the patient was cognitively impaired. The patient worked from and lived independently. Deficits were reported after. This course of events is inconsistent with sequelae of concussion or traumatic brain injury. Neuropsychological testing has found evidence of depression and the patient was undergoing counseling for depression from onward. It's not clear that the patient has suffered traumatic brain injury or that the current deficits are due to traumatic injury. Therefore, the requested 30 hours of Pate Rehabilitation's post-acute day neuro program (6 hours per day, 5 days a week) is not medically necessary and appropriate.

The claimant was evaluated. He stated that the Prodrin was very effective at relieving his headaches. It was noted that cognitive therapy had not yet been approved "although this treatment is a condition for his return to work." He continued to complain of tinnitus and hearing aids were recommended. He was not examined at this visit. ASSESSMENT: His post-traumatic headaches respond to Prodrin. He needs cognitive therapy. PLAN: We are awaiting approval for cognitive therapy. He will follow up in six weeks.

UR. RATIONALE: The patient does not have moderate or severe cognitive dysfunction. The patient was able to continue to work until. The patient has no physical limitations that would require a day program. The request does not meet criteria for an acute day neuro program. Per my conversation, the patient underwent repeat neuropsychological evaluation and the recommendation was made for additional neuropsychological treatment. The patient's condition is not medically complex. There is no indication that the patient is unsafe. The patient may benefit from some cognitive rehabilitation, but a day program with six hours per day of treatment is not medically necessary.

completed forms for xxxxx for due to "he sustained a closed head injury that has caused cognitive impairment."

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The previous adverse decisions are upheld. Provided is a description of head injury occurring , and discharged the same day. Subsequent course is not consistent with sequelae of traumatic brain injury from a significant head injury. Mild cognitive dysfunction has been reported, but prognosis from head injury is that the patients would get better over time or stabilize but not become progressively worse after almost a year following injury. There is no documentation that he is unable to feed orally. This patient may benefit from some cognitive rehabilitation, but the requested 30 hours of Pate Rehabilitation's post-acute day neuro program (6 hours per day, 5 days a week) does not meet ODG criteria for Interdisciplinary rehabilitation program for traumatic brain injury and is not medically necessary or appropriate.

ODG:

<p>Interdisciplinary rehabilitation programs (TBI)</p>	<p>Criteria for Interdisciplinary brain injury rehabilitation programs (postacute care):</p> <p><u>Admission (applies to moderate and severe TBI):</u></p> <ul style="list-style-type: none"> • GCS level from 3 to 12 in the initial 24 hrs, severe at 3-7 GCS and moderate at 8-12 GCS, with moderate TBI generally including loss of consciousness > 30 min, loss of memory > 1 day, altered MS > 1 day, &/or structural changes on CT or MRI (while the initial GCS score is usually used to determine severity, there are a minority of patients whose GCS scores will deteriorate within the first 24 to 48 hours, & some injuries can progress over a few weeks, as in the case of a slow, subdural bleed); & • Mobility and functional activity limitations, including vestibular (balance and coordination) problems; & • Able to tolerate comprehensive rehab program 3-4 hours/day, 5 days/week; & • Has potential to follow visual or verbal commands and agree to actively participate; & • Purposeful response or voluntary movement to external stimuli; & • Able to sit supported 1 hour/day; & • Preadmission assessment documented by licensed clinician including a proposed treatment plan indicating <ul style="list-style-type: none"> o Diagnoses; & o Short/long term goals (specific, quantified, objective) and estimated time to achieve goals; & • Specific projected treatments, duration, intensity; & • Careful attention to transition of care [exchange of info, review of meds and procedures and early discharge planning] from hospital to residential transitional rehabilitation facilities to prevent repeat hospitalizations. <p><u>Day Treatment (i.e., outpatient):</u></p> <ul style="list-style-type: none"> • Treatment is provided under medical prescription by a Physiatrist, Neurologist or other physician with brain injury experience, & • Provide services that are within the scope of services provided under CARF as a brain injury rehabilitation program, & • Patient able to benefit from intensive therapy (equal to or greater than 4 hours per day, 5 days per week), & at least one of the following: <ul style="list-style-type: none"> o Patient requires neurobehavioral treatment for mild behavioral deficits, or o Patient demonstrates moderate to severe cognitive dysfunction, or o Patient requires treatment from multiple rehabilitation disciplines, or o Patient diagnosed with mild to moderate postconcussion syndrome, or o Patient is unable to feed orally, & • Care provided is NOT custodial care, but is focused on recovery and progress is demonstrated. • Patient ambulates 50 feet with supervision. <p><u>Continued Stay:</u></p> <ul style="list-style-type: none"> • Ongoing comprehensive rehab program with at least 3 disciplines and 4 hours/day, 5
--	--

	<p>days/week; &</p> <ul style="list-style-type: none"> • Measurable progress documented toward pre-established goals with gains sustained; & • Mental status change and neurological assessment ongoing; & • Neurologic change and neurological assessment ongoing; & • Pain management addressed; & • No longer than 2-4 weeks without evidence of significant demonstrated efficacy as documented by subjective and objective gains; <ul style="list-style-type: none"> o However, it is also not suggested that a continuous course of treatment be interrupted solely to document these gains, if there are preliminary indications that they are being made on a concurrent basis; o Interdisciplinary summary reports that include treatment goals and progress assessment with objective measures, must be made available upon request at least on a bi-weekly basis during the course of the treatment program. • <i>Residential Transitional Rehabilitation:</i> <ul style="list-style-type: none"> o Target LOS up to 60 - 120 days for patients with moderate to severe injuries; & o Longer end of range depending on acute LOS (with contracted IRF LOS now below 14 days, and trending toward 10, greater levels of disability are presented at admission to residential transitional rehabilitation, requiring longer transitional rehabilitation LOS); & o Progress review every 2 to 4 weeks; & o Program continuation dependent upon demonstrated progress; & o Residential transitional rehabilitation LOS that extends to vocational return may be longer; & o LOS for patients admitted to residential transitional rehabilitation for late rehabilitation may be longer, ranging between 180 to 240 days. o Discharge: <ul style="list-style-type: none"> - Home environment safe and accessible; & - Patient or caregiver demonstrate ability to manage transfers or functional mobility (e.g., ambulation, wheelchair), ADLs; & - Comprehensive written discharge and teaching instructions reviewed. • <i>Day Treatment:</i> <ul style="list-style-type: none"> o Total treatment duration should generally range up to 4 to 6 months; & o If treatment duration in excess of 6 months is required, a clear rationale for the specified extension and reasonable goals to be achieved should be provided; & o Longer durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility; & o At the conclusion and subsequently, re-enrollment in repetition of the same or similar rehabilitation program only if medically warranted for the same condition or injury or exacerbation of injury; & o Suggestions for treatment post-program should be well documented and provided to the referral physician; the patient may require time-limited, less intensive post-treatment with the program itself; & o Defined goals for these interventions and planned duration should be specified. o For individual outpatient therapies, see specific entries in ODG.
--	--

IRO REVIEWER REPORT TEMPLATE -WC

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**